Grand Island
REGIONAL MEDICAL CENTER

**Medical Records Request**

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City, State, Zip: _____

**Information Requested:**

- ☐ Labs/Pathology Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Progress Notes
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation/Clinic Note
- ☐ Billing/Claim Forms
- ☐ Entire Medical Record

**Dates of Service for Records Requested: _____**

**Special Release Requested:**

☐ Mental/Behavioral Health Notes ☐ HIV/AIDS testing ☐ Alcohol/Drug use, abuse, treatment

**Initials: _____Date: _____**

**Purpose of Disclosure:**

☐ Personal ☐ Insurance ☐ Legal ☐ Continuity of Care

**Recipient Information:**

Name: _____ Phone: _____

Address: _____

Fax: _____ Email: _____

My completion of this form serves as authorization for Grand Island Regional Medical Center (GIRMC) to disclose the specified records to the above listed person or group. I understand that once my information leaves GIRMC, GIRMC is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Requestor Signature: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

**Office Use Only**: Requestor Identification Verified

Initials: _____ Date: _____